

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03191 2900

## 1. PLACE OF DEATH:

County Prince George'sCity or town Landover  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County TechetCity or town Landover  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jessie Allen

## 3. (b) Social Security Number

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Heriam Allen7. Birth date of deceased (mo., day, yr.) October 17, 1861  
B.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 85 Months 5 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace New London, Iowa  
(Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name John C. Armstrong13. Birthplace Indiana14. Maiden name Eugene E. Wickold15. Birthplace Iowa16. Informant Mr. Lee LawrenceAddress Easton, Md. P.D.17. (Burial, cremation, or removal, Which?) Removal Date thereof March 31, 1947  
(month) (day) (year)Cemetery or crematory Union HillLocation Washington, D.C.18. Funeral director Wells & ClarkAddress Easton, Md.19. 4/1 19 47 N.B. Neeruss  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 47 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 47 19 47, to March 31 19 47, and that I last saw her alive on March 31 19 47

Immediate cause of death \_\_\_\_\_

Cerebral hemorrhage DURATION 1 dayDue to Arteriosclerosis 4 yearsDue to Hypertension

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following: None

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. W. C. Starn M.D. or other \_\_\_\_\_Address Easton Md Date signed 4-1-47

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 03192 2906

## 1. PLACE OF DEATH:

County Talbot CountyCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3-11-47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Medford Baynard

## 3. (b) Social Security Number

4. Sex m5. Color or race w

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Mrs. Della O. Baynard6. (c) If alive, give age 57 years7. Birth date of deceased (mo., day, yr.) April 11, 1884

8. AGE: Years Months Days If less than one day

62 yrs. 11 mos. 3 days \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Willet Co. Md.  
(Town, county, and state)10. Usual occupation Hotelman

11. Industry or business

12. Name William Baynard13. Birthplace Md. Talbot Co.14. Maiden name Margaret S. Brewer15. Birthplace Talbot Co. Md.16. Informant Mrs. James M. BaynardAddress Easton Md.17. Buried Date thereof Mar 17 1947  
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory Spring HillLocation Easton Md.18. Funeral director Wm. E. Newman SonAddress Easton Md.19. 3/15 19 47 M. S. Neesie  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 19 47 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/12 19 47, to 2/14 19 47and that I last saw him alive on 2/14 19 47

Immediate cause of death \_\_\_\_\_

## DURATION

Myocardial Infarction 2 daysDue to Arteriosclerotic Heart Disease 6 mos.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. Col M. D.Address Easton Md. Date signed 3/15/47

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

03193

Reg. Diat. No. 2900

## 1. PLACE OF DEATH:

County... Ta. 1stCity or town... Easton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 daysHospital, institution, or street address where death occurred  
Memorial HospitalHow long in hospital or institution? 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... 2a.City or town... Centerville  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)2(a) If veteran, name War... ✓

## 3. (a) FULL NAME

Mrs. Nannie D Chambers

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced ✓6. (b) Name of husband or wife John H. Chambers7. Birth date of deceased (mo., day, yr.) April 15, 18748. AGE: Years 72 Months 11 Days 10 If less than one day  
.....hrs. ....min.9. Birthplace Johnson Co. Indiana  
(Town, county, and state)10. Usual occupation H W

## 11. Industry or business

12. Name James C. Drybread13. Birthplace Indiana14. Maiden name Martha A. Wheeler15. Birthplace Ohio16. Informant Mrs. W. J. LacyAddress 251 York Ave; Franklin, Ind.17. Burial Date thereof 3/28/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ChesterfieldLocation Centerville Ind18. Funeral director Barton BrosAddress Centerville Maryland19. 3/26 19 47 N. H. Nerius  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/25 19 47 at 8:59 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
3 7 19 47, to 3 25 19 47  
and that I last saw him alive on 3 24 19 47Immediate cause of death Coronary occlusion DURATION 3-5 47Due to Coronary Insufficiency

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE PE Cox M. D. or otherAddress Centerville Ind Date signed.....

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

## CERTIFICATE OF DEATH

Reg. Dist. No. 03194  
2940

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town Vienna  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Vienna  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Geraldine Dewitt

## 3. (b) Social Security Number

4. Sex Female5. Color or race Col

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife \_\_\_\_\_

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 19468. AGE: Years 7 Months 18 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Highman, Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Robert Dewitt13. Birthplace Mississippi, Mo.14. Maiden name Jessie Jenkins15. Birthplace Columbia, D. C.16. Informant Robert DewittAddress Highman, Md.17. Burial Date thereof 3/31/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shenandoah, Col.Location Shenandoah, Md.18. Funeral director J. Thomas MarshallAddress 27 Bonchamps, Md.19. March 31, 1947 G. J. Harrison  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29, 1947 to March 29, 1947and that I last saw him alive on March 29, 1947Immediate cause of death Apoplexy, hyperemia, stroke

DURATION

Due to apoplexy, hyperemia, stroke

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Apoplexy Date of March 29, 1947Where did injury occur? Apoplexy (City or town) (County) (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury Stroke Injured at work? no23. SIGNATURE Wm. J. Reese, M.D. M. D. or otherAddress Highman, Md. Date signed March 30, 1947



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 03195 2900

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 18 days  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Henry A Farley  
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, divorced M

## 3. (b) Social Security Number

8.(b) Name of husband or wife Elizabeth Farley

7. Birth date of deceased (mo., day, yr.) \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 59 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hillsboro, N.H.  
 (Town, county, and state)

10. Usual occupation Farmer

## 11. Industry or business

12. Name Frank Farley13. Birthplace New Hampshire14. Maiden name Elwora Collins15. Birthplace New Hampshire16. Informant Mrs. Mae FarleyAddress Hillsboro, N.H.17. Removal Date thereof 3/15/47

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Concord N.H.Location Concord N.H.18. Funeral director Virgil Brown & SonAddress Easton, Md.

3/13 47 N.H. Neer

19. (Date rec'd by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 47 at 1:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him alive on 3/12/47 19 47

Immediate cause of death \_\_\_\_\_ DURATION

\_\_\_\_\_ 3 days

Due to Myocardial Infarction Myocardial InfarctionDue to arteriosclerotic heart disease arteriosclerotic heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE 13 Col M.D. M. D. or otherAddress Easton, Md. Date signed \_\_\_\_\_

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 03196  
 Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hr. 21 min.  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 2 hr. 21 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joan Elizabeth Foster

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Infant

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1946 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months 5 mos Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Memorial Hospital Easton, Md.  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

## 11. Industry or business

12. Name James E. Foster

13. Birthplace Talbot County

14. Maiden Name Kathleen Kammerle

15. Birthplace Baltimore

16. Informant Mrs. J. E. Foster

Address Concord, Md.

17. Burial Date thereof 3/11/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Windsor Hill

Location Easton, Md.

18. Funeral director Carl W. Hafford

Address Easton, Md.

19. 3/10 47 N. H. Neer  
 (Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 47 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/8/47 to 3/9/47  
 and that I last saw him alive on 3/9/47

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Pneumonia, lobes, at upper 24 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. E. Foster M. D. or other \_\_\_\_\_

Address Easton, Md. Date signed 3-10-47

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

## CERTIFICATE OF DEATH

03197

Reg. Dist. No. 2906

## 1. PLACE OF DEATH:

County TalbotCity or town Near Cordova  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(If newborn infants give residence of mother)

State Maryland County TalbotCity or town Near Cordova  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Guy Searle Harris

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Chas. Harris

B.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

June 27, 1911

8. AGE:

Years

Months

Days

If less than one day

35812

hrs.

min.

9. Birthplace

Cordova, Talbot, Maryland  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER

FATHER

12. Name

Warner Guy

13. Birthplace

Delaware

14. Maiden name

Maggie Devernick

15. Birthplace

Talbot Co. Md.

16. Informant

Chas. Harris

Address

Cordova, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 12, 1947  
(month) (day) (year)

Cemetery or crematory

Santtown

Location

Near Hillsboro, Md.

18. Funeral director

W. Virgil Moore, Son -

Address

Denton, Ind.

19.

(Date rec'd by registrar)

19. 47

N.H. Nearies

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1947, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 43 1947, to March 9 1947and that I last saw him alive on March 2 1947

Immediate cause of death

Cerebral thrombosis, sudden

DURATION

Due to

Hypertensive arterial disease

Due to

diabetes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Kurt Pedersen M.D.

M. D. or other

Address

Chesapeake, Md.Date signed 3/11

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 7910

03198

## 1. PLACE OF DEATH:

County.....Talbot  
 City or town.....ST. Michaels.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....50 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State.....Maryland.....County.....Talbot  
 City or town.....St. Michaels.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Arthur G. Hubbard

## 3. (b) Social Security Number

None

4. Sex.....male  
 5. Color or race.....white  
 6.(a) Single, married, widowed, or divorced.....Single

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 29, 1947.....19.....at.....11:45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Feb. 15, 1947.....19.....to.....Mar. 29, 1947  
 and that I last saw him alive on.....Mar. 26, 1947.....19.....

Immediate cause of death.....  
 Coronary Disease.....

## DURATION

Due to.....Chr. Rheumatism.....6 mos.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Date of .....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address.....St. Michaels, Md.....Date signed.....3.31.47

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....July 19, 1876  
 8.(c) If alive, give age.....years

8. AGE: Years.....70.....Months.....8.....Days.....10.....If less than one day.....hrs. ....min.

9. Birthplace.....St. Michaels, Talbot Co., Md.  
 (Town, county, and state)

10. Usual occupation.....Waterman

11. Industry or business.....

FATHER 12. Name.....John T. Hubbard

13. Birthplace.....Annapolis, Maryland

MOTHER 14. Maiden name.....Georgiana Coffin

15. Birthplace.....Baltimore, Maryland

19. Informant.....Marion S. Hubbard

Address.....St. Michaels, Md.

burial

17. (Burial, cremation, or removal, Which?).....Date thereof.....April 1, 1947

Cemetery or crematory.....Olivet Cemetery

Location.....St. Michaels, Md.

18. Funeral director.....Newnam &amp; Harrison

Address.....St. Michaels, Md.

19. Mar. 31, 1947.....E. W. Seth

(Date rec'd by registrar)

Registrar



MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

Reg. Dist. No. 031980 2780

## 1. PLACE OF DEATH:

County... Talbot  
 City or town... Easton Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death... 3 hrs. 15 min.  
 Hospital, institution, or street address where death occurred:  
Memorial Hospital  
 How long in hospital or institution? 3 hrs. 15 min.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Caroline  
 City or town... Greensboro Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... ✓

## 3. (a) FULL NAME

Mellie Sarman

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Mrs. Harry B. Sarman

## 7. Birth date of deceased (mo., day, yr.)

## 6. (c) If alive, give age... years

## 8. AGE:

Years

Months

Days

If less than one day

50

hrs. min.

## 9. Birthplace

Wilmington, Del.  
(Town, county, and state)

## 10. Usual occupation

H. W.

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Daniel Hickman

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Address

## 17.

(Burial, cremation, or removal) Which?

Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

Address

## 19.

(Date registered by registrar)

19

47M. S. Newsum  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947 at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/5/1947 to 3/5/1947  
and that I last saw him alive on 3/5/1947

Immediate cause of death

DURATION

Coronary Thrombosis 2 weeks

Due to

arteriosclerotic heart disease 1 year(?)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 3/6/47

RECEIVED

MAR 17 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

## CERTIFICATE OF DEATH

Reg. Dist. No. 03200

## 1. PLACE OF DEATH:

County Palmer  
 City or town Trappe  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Palmer  
 City or town Trappe  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION) no  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Rachel Anne Johns

## 3. (b) Social Security Number

no

4. Sex female 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Rudolph Johns  
widow 6. (c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) Mar 1 1851

8. AGE: Years 86 Months — Days 26 If less than one day — hrs. — min.

9. Birthplace Trappe md  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Millwife Nurse

12. Name William King Rakes

13. Birthplace Trappe md

14. Maiden name Margaret Muse

15. Birthplace Salisbury Pa

16. Informant Ida Compher

Address Trappe md

17. Burial Date thereof Mar 29-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Scott

Location Trappe md

18. Funeral director James H. Stewart

Address Salisbury md

19. Mar 29 19 47 Johnston  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-26- 19 47 at 10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-24- 19 47 to 3-26- 19 47

and that I last saw her alive on 3-26- 19 47

Immediate cause of death Cerebral hemorrhage DURATION 3 days

Due to Arteriosclerosis years

Other conditions Diabetes years

(Include pregnancy within 3 months of death)

Major findings of operations no

Antopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide no Date of no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. M. C. Stearn M.D.

Address 3-28-47 Easton Md

RECEIVED

MAR 31 1947

BUREAU V. S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 2920

## 1. PLACE OF DEATH:

County Talbot  
 City or town Trappe, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town Trappe  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Doris C. Kirby

## 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife also M. Kirby  
 6. (c) If alive, give age 60 years  
 7. Birth date of deceased (mo., day, yr.) May 26, 1868  
 8. AGE: Years 78 Months 9 Days 16 It less than one day  
 hrs. min.

9. Birthplace Trappe, Talbot, Maryland  
(Town, county, and state)10. Usual occupation Retired Farmer

## 11. Industry or business

12. Name Wm A. Kirby13. Birthplace Md.14. Maiden name Margaret Armstrong15. Birthplace Pa.16. Interment Mrs Doris C. KirbyAddress Trappe, Md.17. Burial, cremation, or removal (which?) Buried Date thereof March 6, 1947  
(month) (day) (year)Cemetery or crematory Spring HillLocation Trappe, Md.18. Funeral director W. H. CarlAddress Edison, Md.19. March 6 19 47 J. H. B. Ross  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 47 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 2nd 19 47 to March 4 19 47and that I last saw him alive on March 2nd 19 47Immediate cause of death Hypostatic Pneumonia

DURATION

3 days

Due to

Due to

Other conditions

Atherosclerosis  
Multiple Aneurysms  
(Include pregnancy within 8 months of death)4 years  
20

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. B. Ross

M. D. or other

Address Trappe, Md. Date signed 3/6/47

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8 1947

BUREAU V B

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH.

County DalbotCity or town Easton Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death 15 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County DalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Agd. W. Jones  
(If rural, give LOCATION)

2. (a) If veteran, name war:

## 3. (a) FULL NAME

Edith Lucy Thomas

## 3. (b) Social Security Number

4. Sex female5. Color or race white6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 3, 1866

6. (c) If alive, give age years

8. AGE: Years 80 Months 9 Days 3  
If less than one day hrs. min.9. Birthplace Dalbot County md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Edward N. Thomas13. Birthplace Dalbot Co. St. Michael md14. Maiden name Fannie Thomas15. Birthplace Dalbot Co. St. Michael md16. Informant hus - Mrs. HardieAddress Easton md17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof 3/7/47

(month) (day) (year)

Cemetery or crematory Spring Hill CemeteryLocation Easton md18. Funeral director Carlisle HaffordAddress Easton md19. 3/6 47 N. H. Neerive

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 March 19 47 at 10:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 19 46 to 6 Mar 19 47and that I last saw or alive on 19Immediate cause of death Cerebral thrombosisDue to Cerebral arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phyllis M. Hamilton M.D.Address 24 E. River St. Easton Date signed Apr 47

RECEIVED

MAR 12 1947

BUREAU V S

2-35

VS A15

Evidence for addition of  
day of death shown on MA  
Film # 109-3121147

2411 N. Charles St., Baltimore 190

★ 03203  
2910  
Reg. Diat. No. ....

Reg. Diat. No. ....

1. PLACE OF DEATH: County <u>Talbot</u> City or town <u>outside Neavitt</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Talbot</u> City or town <u>Tilghman</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war <u>X</u>			
3. (a) FULL NAME <u>Charles L. MACER</u>				3. (b) Social Security Number <u>213-14-6040</u>			
4. Sex <u>MALE</u>		5. Color or race <u>Colored</u>		6.(a) Single, married, widowed, or divorced <u>Married ?????</u>			
6.(b) Name of husband or wife <u>Rosie E. Macer</u>				6.(c) If alive, give age <u>44</u> years			
7. Birth date of deceased (mo., day, yr.) <u>2-7-1905</u>							
8. AGE: Years <u>42</u>		Months <u>0</u>		Days <u>25</u>		If less than one day _____.hrs. _____.min.	
9. Birthplace <u>Federalburg, Caroline County, Md.</u> (Town, county, and state)							
10. Usual occupation <u>Laborer.</u>							
11. Industry or business <u>Packing house.</u>							
FATHER		12. Name <u>Cannon</u>		13. Birthplace <u>Unknown</u>			
MOTHER		14. Maiden name <u>Annie Turner</u>		15. Birthplace <u>Federalburg, Md.</u>			
16. Informant <u>Rosie E. Macer</u> Address <u>Eastport, Md.</u>							
17. Burial <u>Burial</u> Date thereof <u>3-6-1947.</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Federalburg Colored Cem.</u> Location <u>Federalburg Md.</u> <u>J. Norman Marshall,</u> 18. Funeral director Address <u>St. Michaels, Md.</u>							
19. <u>3-6-1946</u> (Date rec'd by registrar)				Registrar			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>March 5, 1947</u> at _____							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____ and that I last saw h. _____ alive on _____ 19____							
Immediate cause of death _____ DURATION _____							
<u>Exposure to freezing elements</u> ? hours							
Due to _____							
Due to _____							
Other conditions _____							
(Include pregnancy within 8 months of death)							
Major findings of operations _____							
Date of op. _____							
Autopsy results _____							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>accident</u> Date of _____ Where did injury occur? <u>Talbot</u> <u>Md</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>on march</u> Means of injury <u>froze to death</u> Injured at work? <u>no</u>							
23. SIGNATURE <u>Louis D. Harty Md Dep Health</u> M. D. or other _____ Address <u>Easton Md</u> Date signed <u>3-3-47</u>							

RECEIVED

MAR 17 1947

BUREAU V S

2-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

## CERTIFICATE OF DEATH

Reg. Dist. No. 03204 290

## 1. PLACE OF DEATH

County Talbot  
 City or town Easton, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all of life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD County Talbot  
 City or town Easton, MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

James Mackey  
 4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 18 - 1864

8. AGE: Years 82 Months 4 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Easton, Rural Talbot Co. Md.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Farm12. Name Theodore Mackey13. Birthplace Royal Oak, Md.14. Maiden name Rebecca Barnett15. Birthplace Royal Oak, Md.16. Informant Velen WallaceAddress Easton, Rural, Md.17. Burial Date thereof Mar. 14, 1947  
(Burial, cremation, or removal, White) (month) (day) (year)Cemetery or crematory St. Pauls CemeteryLocation Easton Rural Diamond Corner18. Funeral director John D. WilliamsAddress Easton, Md.19. 314 47 N. H. Norris  
(Date, rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 11, 1947 at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

Coronary occlusion  
 Due to Senile arteriosclerosis

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Louis A. Wooty, MD Dep. Med. Ex.  
 Address Easton, Md. M. D. or other \_\_\_\_\_  
 Date signed 3-15-47

RECEIVED

MAR 20 1947

BUREAU

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03205

Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County TALBOTCity or town EASTON, MD.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 7 DAYS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County CamdenCity or town Bridgeport  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

MRS. ALEXANDER SCOTT

## 3.(b) Social Security Number

165-03-3191

4. Sex

7n

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife MRS. ALEXANDER SCOTT6.(c) If alive, give age 66 years

7. Birth date of

deceased (mo., day, yr.)

1981

8. AGE:

Years

Months

Days

If less than one day

66

hrs. min.

9. Birthplace

Scotland

(Town, county, and state)

10. Usual occupation

RETIRED Salesman

11. Industry or business

FATHER

12. Name

JOHN SCOTT

13. Birthplace

SCOTLAND

MOTHER

14. Maiden name

Isabella COWAN

15. Birthplace

SCOTLAND

18. Informant

MARY W. SCOTT

Address

ST. MICHAELS, MD.

17.

(Burial, cremation, or removal, which?)

Date thereof

3/25/47  
(month) (day) (year)

Cemetery or crematory

Hillside

Location

Hillside, Pa.

18. Funeral director

NEWNAM & HARRISON

Address

ST. MICHAELS, MD.

19.

(Date rec'd by registrar)

3/2847

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21-47 19 47, at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

MARCH 10 19 47, to MARCH 21 19 47and that I last saw him alive on 6:30 3-21 19 47Immediate cause of death CEREBRO-VASCULARACCIDENT

DURATION

Due to

Due to

Other conditions PERFORATED DUODENALULCER

(Include pregnancy within 8 months of death)

Major findings of operations WALLED OFF ABSCESSAROUND DUODENUMDate of op. MARCH 21-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

M. Palmer

M. D. or other

Address Easton, Pa. Date signed \_\_\_\_\_



RECEIVED  
APR 3 1947  
BUREAU V 8

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*Handwritten signature and date:*  
12-1-47

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 03206

### 1. PLACE OF DEATH:

County Talbot  
City or town St. Michaels  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 70 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot  
City or town St. Michaels  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

George E. Shockley

### 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower  
6. (b) Name of husband or wife Laura Beynard  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) June 8, 1862  
8. AGE: Years 84 Months 9 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Somerset, Co., Md.  
(Town, county, and state)  
10. Usual occupation Waterman  
11. Industry or business  
12. Name David A. Shockley  
13. Birthplace Somerset Co., Md.  
14. Maiden name Mary A. Jones  
15. Birthplace Somerset Co., Md.

16. Informant John R. Shockley  
Address St. Michaels, Md.  
17. Burial Date thereof March 27, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Olivet Cemetery  
Location St. Michaels, Md.  
18. Funeral director Newnam & Harrison  
Address St. Michaels, Md.  
19. Mar. 20 19 47 E. W. Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24, 1947 at \_\_\_\_\_ M  
I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 24 19 47 to Mar 24 19 47  
and that I last saw him alive on Mar 24, 1947  
Immediate cause of death Arteriosclerotic Nephros-  
is  
Due to Generalized Arterio-  
sclerotic Hypertension  
(Include pregnancy within 3 months of death)  
Major findings of operations None  
Date of op. \_\_\_\_\_  
Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ✓ Date of ✓  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) ✓  
Means of injury ✓ Injured at work? ✓  
23. SIGNATURE Philip S. Newnam M. D. or other  
Address St. Michaels, Md. Date signed 3-26-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

★ 03207

Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County TalbotCity or town Cordova  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County TalbotCity or town Cordova  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Jesse Mallikin Skinner

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married - s.

6. (b) Name of husband or wife

Ethel Benson Skinner6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

March 17, 1883

8. AGE:

Years

Months

Days

If less than one day

6400

hrs.

min.

9. Birthplace

Q.A. Co. Md.

(Town, county, and state)

10. Usual occupation

carpenter

11. Industry or business

self

MOTHER FATHER

12. Name

Richard S. Skinner

13. Birthplace

md.

14. Maiden name

Lenora Wendrell

15. Birthplace

md.

16. Informant

Mrs. Milby Geib

Address

Cordova Md.

17.

(Burial, cremation, or removal)

Date thereof

March 15, 1947

Cemetery or crematory

Chesterfield

Location

Centreville, Md.

18. Funeral director

R. Ellis Clark

Address

Easton, Md.

19.

(Date rec'd by registrar)

3/17/47N.H. Neuvier

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1947 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. \_\_\_\_\_, to \_\_\_\_\_, 19. \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19. \_\_\_\_\_

Immediate cause of death

Coronary occlusion

DURATION

Immediate

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Louis D. Harty MD, Dep Med Ex.

M. D. or other

Address \_\_\_\_\_

Date signed 3-13-47

RECEIVED  
MAR 17 1947  
BUREAU OF

1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03208

Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)Street No. S. Curran St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Female 5. Color of race W. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife John H. Sullivan7. Birth date of deceased (mo., day, yr.) October 1894 6. (c) If alive, give age..... years8. AGE: Years 52 Months 5 Days 1 If less than one day..... hrs. .... min.9. Birthplace Talbot Co. Md.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business St. Johns12. Name Charles H. Gault13. Birthplace Maryland14. Maiden name Annis Sullivan15. Birthplace Maryland16. Informant Chas. H. Gault (Bro.)Address Easton, Md.17. Burial Date there March 29 1947  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Spring HillLocation Easton, Md.18. Funeral director L. Ellis ClarkAddress Easton, Md.19. 3/29 19 47 N. D. Neenan  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 47 at 7:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 24th 19 47 to Mar. 27th 19 47and that I last saw her alive on March 26th 19 47Immediate cause of death chronic disorder DURATION 1 1/2 yrs.  
heart (mitral stenosis)Due to Rheumatism 6 mos.

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

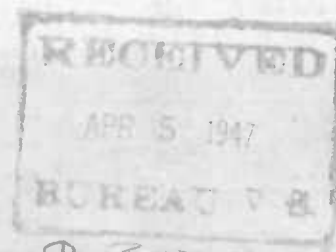
Means of injury Injured at work?

23. SIGNATURE William S. Symons M. D. or otherAddress Easton Md. Date signed 3/27/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (U)

## CERTIFICATE OF DEATH

Reg. Dist. No. 03209 2900

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Stittman, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Thomas, Carrie

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mr. Ogle Thomas

7. Birth date of

deceased (mo., day, yr.)

April 20, 1879

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

67

.....hrs. ....min.

9. Birthplace

Boyman Talbot Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER  
MOTHER

12. Name

Martin Schell

13. Birthplace

Germany

14. Maiden name

Mary A. Spear

15. Birthplace

Caroline Co., Md.

16. Informant

Ogle Thomas

Address

Wittman, Maryland

17.

(Burial, cremation, or removal, Which?)

Date thereof

Mar. 8, 1947

(month) (day) (year)

Cemetery or crematory

Wittman

Location

Wittman, Md.

18. Funeral director

Newman & Harrison

Address

St. Michael, Md.

19.

(Date rec'd by registrar)

19

47N. H. Neuman

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 4, 1947 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 17, 1947 to March 4, 1947and that I last saw him alive on March 4, 1947

Immediate cause of death

Cerebral Thrombosis 2 months

DURATION

Due to

Arteriosclerosis

Due to

Other conditions

Diabetes mellitus - mild

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE

M. V. Palmer, M.D.

M. D. or other

Address Easton, Maryland Date signed 3/9/47

RECEIVED

MAR 12 1947

BUREAU

2-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

## CERTIFICATE OF DEATH

03210

Reg. Dist. No. 2910

## 1. PLACE OF DEATH:

County Talbot  
 City or town St. Michaels  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town St. Michaels  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mollie H. Thomas

## 3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow  
 6.(b) Name of husband or wife Cornelius Thomas  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept. 11, 1871  
 8. AGE: Years 75 Months 5 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace St. Michaels, Talbot Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

12. Name Denny W. Williams  
 13. Birthplace Talbot Co., Md.  
 14. Maiden name Annie Holtz Williams  
 15. Birthplace Balto, Md.

16. Informant Miss Isabel Thomas  
 Address St. Michaels, Md.

17. Burial Date thereof Mar. 3, 1947  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Olivet Cemetery  
 Location St. Michaels, Md.

18. Funeral director Newnam & Harrison  
 Address St. Michaels, Md.

19. Mar 3 19 47 John L. Harrison  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 47 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 19 47 to Mar. 1 19 47

and that I last saw him alive on Mar. 1, 1947 19 47

Immediate cause of death Thromboses DURATION 5 days  
left leg.

Due to blood clot in leg.

Due to \_\_\_\_\_

Other conditions she had recovered from lobar pneumonia a day before death.

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. Harrison Williams M. D. or other

Address St. Michaels, Md. Date signed 3/2/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1947

BUREAU

2-38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 142

## CERTIFICATE OF DEATH

Reg. Dist. No. 8900

03211

## 1. PLACE OF DEATH:

County... TalbotCity or town... Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

412 South St.

How long in hospital or institution?

12 yrs.

## 3. (a) FULL NAME

Robert Gregory Thomas

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

c

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

March 11, 1947

8. AGE:

Years

Months

Days

If less than one day

24

hrs.

min.

9. Birthplace

Easton Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Faye Davidson

13. Birthplace

Talbot Co. Md.

MOTHER

14. Maiden name

Novella Thomas

15. Birthplace

Talbot Md.

16. Informant

Iola Harris

Address

Easton Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

3/15/47

Cemetery or crematory

Richards

Location

Easton Md.

18. Funeral director

Along Hale

Address

Easton Md.

19.

(Date rec'd by registrar)

19 47M. H. Harris

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... TalbotCity or town... Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 412 South St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 12 19 47 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

Atelectasis

Due to

Due to

Other conditions

84a

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis J. Harty Md.

M. D. or other

Address

Easton Md.Date signed 3/15/47

RECEIVED

MAR 20 1947

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1-38



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1370

## CERTIFICATE OF DEATH

Reg. Dist. No. 2900

03212

## 1. PLACE OF DEATH:

County Talbot Co.City or town Easton Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Greensboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Arthur John Wrey

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife

Augusta Wrey

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

77516

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

retired farmer

11. Industry or business

FATHER

12. Name

William Wrey

13. Birthplace

md

MOTHER

14. Maiden name

Mary Cook

15. Birthplace

md.

16. Informant

Address

17.

(Burial, cremation, or record. Which?)

Date thereof

(month) (day) (year)

Cemetery or place of

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47H. H. Hevins

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947 at 8:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 13 1947 to March 1 1947and that I last saw him alive on March 1 1947

Immediate cause of death

Coronary Embolus

DURATION

1 hr

Due to

chronic nephritis

Due to

Sclerotic Kidneys

Other conditions

Hypertrophied prostateSuprapubic cystostomy  
(include pregnancy within 3 months of death)

Major findings of operations

Hypertrophied prostate

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

H. H. Hevins M.D.Easton MdMar 2, 1947



RECEIVED

MAR 7 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

## CERTIFICATE OF DEATH

03213  
Reg. Dist. No. 2910

1. PLACE OF DEATH:  
Talbot  
County.....  
City or town.....  
St. Michaels, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Life  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....  
Maryland  
County.....  
Talbot  
City or town.....  
St. Michaels  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

## 3. (a) FULL NAME

John H. W. Wales

## 3. (b) Social Security Number

none

4. Sex.....  
male  
5. Color or race.....  
white  
6. (a) Single, married, widowed, or divorced.....  
married  
6. (b) Name of husband or wife.....  
Mary A. Chaplain  
6. (c) If alive, give age.....  
80 years  
7. Birth date of deceased (mo., day, yr.).....  
March 26, 1861  
8. AGE: Years.....  
85  
Months.....  
11  
Days.....  
28  
If less than one day.....  
hrs. min.

9. Birthplace.....  
St. Michaels, Talbot Co., Md.  
(Town, county, and state)  
10. Usual occupation.....  
Retired Paper Hanger  
11. Industry or business.....

FATHER  
12. Name.....  
John H. Wales  
13. Birthplace.....  
Talbot County, Md.  
MOTHER  
14. Maiden name.....  
Irene Cockey  
15. Birthplace.....  
Kent County, Md.

16. Informant.....  
Wm. P. Wales  
Address.....  
St. Michaels, Md.

17. Burial.....  
Date thereof.....  
March 26, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory.....  
Olivet Cemetery  
Location.....  
St. Michaels, Md.

18. Funeral director.....  
Newnam & Harrison  
Address.....  
St. Michaels, Md.

19. March 26<sup>th</sup> 1947.....  
(Date rec'd by registrar) E. W. Selk Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....  
March 23, 1947 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 20, 1947 to March 23, 1947  
and that I last saw him alive on March 23, 1947

Immediate cause of death.....  
Coronary  
Myocarditis  
DURATION  
1 year

Due to.....  
Chronic Nephritis  
KIDNEYS

Due to.....  
Chronic Hypertrophy  
of Prostate Gland  
10 years

Other conditions.....  
Anaemia  
2 days

(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide.....  
Date of.....  
Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
Means of Injury.....  
Injured at work?

23. SIGNATURE.....  
Robert H. Brink, M.D.  
M. D. or other  
Address.....  
St. Michaels, Md.  
Date signed.....  
3/26/47

RECEIVED

APR 5 1947

BUREAU V B

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 2900

## 1. PLACE OF DEATH:

County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 yrs.  
 Hospital, institution, or street address where death occurred:  
309 S. Hanson St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 309 S. Hanson St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Jane Warner

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Alfred Thos. Warner

7. Birth date of deceased (mo., day, yr.) December 23, 1862 6. (c) It alive, give age 47 years

8. AGE: Years 84 Months 2 Days 25 It less than one day hrs. min.

9. Birthplace Talbot Co. Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

12. Name Hannah B. Fox

13. Birthplace New Jersey

14. Maiden name Hannah B. Fox

15. Birthplace New Jersey

16. Informant James H. Warner

Address Easton, Md.

17. (Burial, cremation, or removal. Which?) Burial

Date thereof March 20, 1947  
 (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton, Md.

18. Funeral director J. C. Clark

Address Easton, Md.

19. 3 19 47  
 (Date rec'd by registrar)

Registrar N. A. Nease

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 47 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 6th 19 47 to March 19 47  
 and that I last saw him alive on March 17th 19 47

Immediate cause of death

arterio sclerosis

DURATION

5 yrs.

Due to

Cerebral thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of Injury

Injured at work?

23. SIGNATURE

William J. Seymour  
Easton

M. D. or other

Address

Date signed 3/18/47

RECEIVED

MAR 25 1947

RECEIVED

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

Reg. Diat. No. 03215  
2900

## 1. PLACE OF DEATH:

County Talbot  
City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days  
Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Baldsboro  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_ ☒

## 3. (a) FULL NAME

Lucy Mae Weaver

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife Robert Weaver

7. Birth date of deceased (mo., day, yr.) March 20, 1879 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 68 Months 11 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Delaware  
(Town, county, and state)

10. Usual occupation H.W.

## 11. Industry or business

12. Name William Wilson

13. Birthplace Delaware

14. Maiden name Lydia Schindler

15. Birthplace Henderson, Ind.

16. Informant Wilson Weaver

Address Henderson, Ind.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 3/7/47  
(month) (day) (year)

Cemetery or crematory Greensboro

Location Greensboro, Md.

18. Funeral director R. B. Rawlings

Address Greensboro, Md.

19. 3/4 47 N.H. Nevius  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 47 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Feb 19 47, to 4 Mar 19 47

and that I last saw a alive on 2 Mar 19 47

Immediate cause of death Myocardial infarct

DURATION

?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hyper tension, cardiac disease

diabetes & cardiac failure  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thos. H. Rawlings M.D.

Address 214 E. Ave. St. Eaten Date signed 4 Mar 47

RECEIVED

MAY 7 1947

BUREAU V.M.

1-35



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03216

## CERTIFICATE OF DEATH

Reg. Dist. No. 198

## 1. PLACE OF DEATH:

County Talbot  
 City or town Proppes rural md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred: no  
 How long in hospital or institution? no

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Talbot  
 City or town Proppes (rural) md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. no  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no war

## 3. (a) FULL NAME

Wilson Wells

## 3. (b) Social Security Number

no

4. Sex Male 5. Color or race a. a. 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Addie Wells  
 7. Birth date of deceased (mo., day, yr.) Aug 15 1865  
 6. (c) If alive, give age but know years  
 8. AGE: Years 81 Months 6 Days 2 If less than one day  
 hrs. min.

9. Birthplace Proppes (rural) md  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Same as above  
 FATHER  
 12. Name Wilson Wells  
 13. Birthplace Proppes (rural) md  
 MOTHER  
 14. Maiden name W. Brown  
 15. Birthplace unknown

16. Informant Mrs Addie Wells  
 Address Proppes md RD  
 17. Burial, cremation, or removal, Which? Burial Date thereof Mar 5 1947  
 (month) (day) (year)  
 Cemetery or crematory Statts M.E.  
 Location Proppes rural md  
 18. Funeral director James H. Stewart  
 Address Salisbury md  
 19. March 4 19 47 Joseph A. Ross  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 47 at P.A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to March 2 19 47  
 and that I last saw him alive on March 2 19 47

Immediate cause of death Carcinoma of the Colon  
 DURATION 1 year

Due to  
 Due to

Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

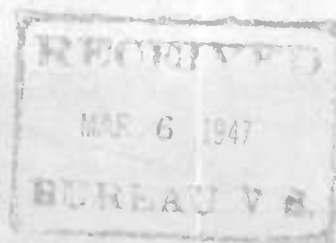
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Harvard T. Webb M.D.  
 M. D. or other  
 Address Easton 1 Md Date signed 3/3/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No. 2900

## 1. PLACE OF DEATH

County TalbotCity or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

202 South St.

How long in hospital or institution?

## 3. (a) FULL NAME

William Smith Wilson Jr.

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 13, 1876

8. AGE: Years Months Days It less than one day

71 0 8 hrs. min.9. Birthplace Caroline Co. Md.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Alfred James Wilson13. Birthplace Delaware14. Maiden name Angie Smith15. Birthplace Maryland16. Informant William S. Wilson Jr.Address 109 La Pair Lane - Towson Md.17. (Burial, cremation, or removal, Which?) BurialDate thereat March 24, 1947

(month) (day) (year)

Cemetery or crematory Spring HillLocation Easton Md.18. Funeral director P. Egan ClarkAddress Easton Md.19. 3/24 1947 N.H. Neemer

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 202 South St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1947 at 7 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....

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MAR 29 1947

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